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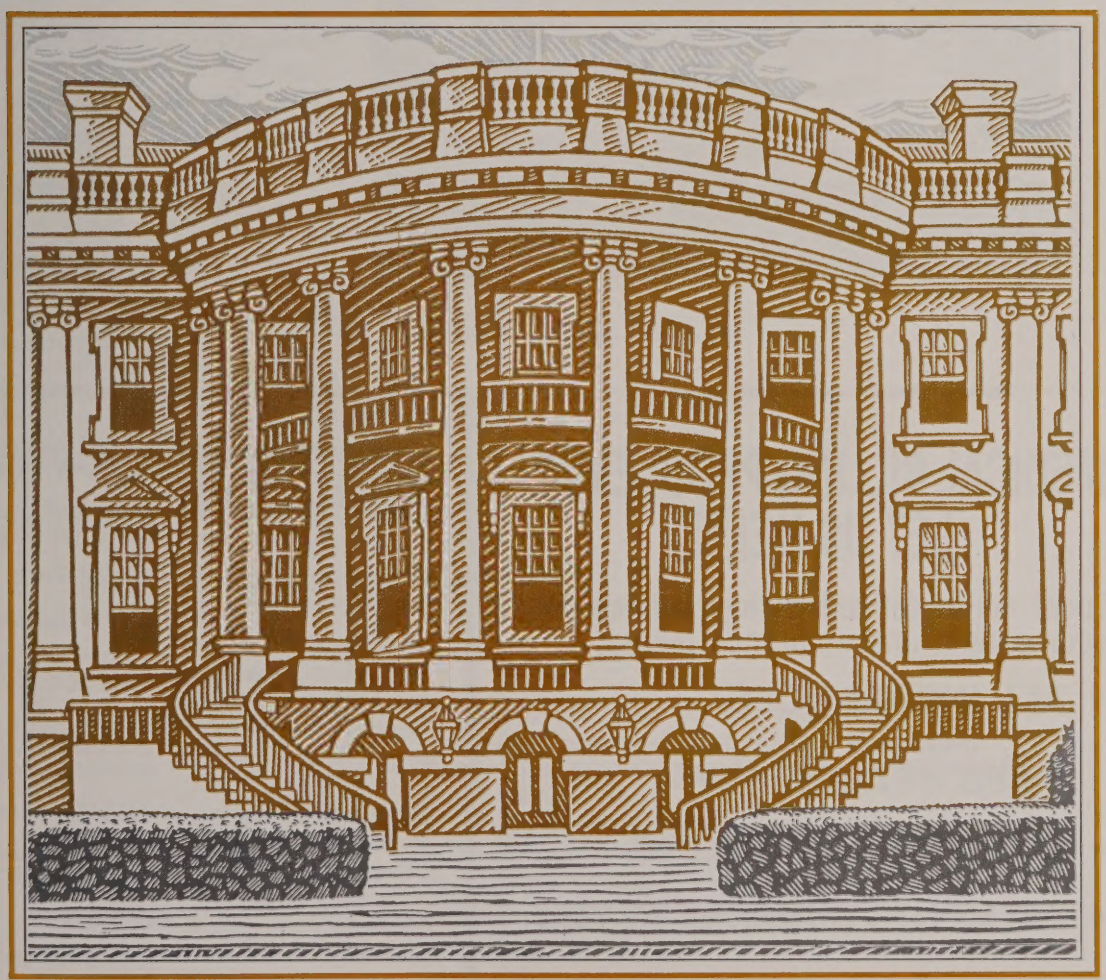

President Clinton Talks About Health Care

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THE
Hampden Hippocrat
MAY—JUNE 1994

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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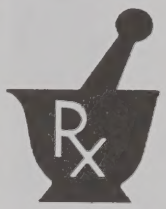

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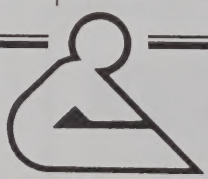
From the Editor

The *California Physician,* the official publication of the California Medical Association, has presented a transcript of a live satellite town meeting between President Clinton and physicians attending the Association's 1994 Annual Session. This provides us with an opportunity to pose questions to the President that are not being asked by the mass media.

In this issue, we also have contributions from Dr. Maura Brennan on Medical Education in Japan and Dr. Jeffrey Kaufman updating us on Optimal Diabetic Foot Care.

It is also the time to say thanks to Don Higby who has served the society and the Hippocrat well during the past five years as co-editor. Don, always a bit over committed, has turned his attention to other more pressing projects. In particular his lucidity of thought and especially his sense of humor will be missed.

Brigid Glackin, M.D.
Editor



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The Changing Perception Of Specialist Physicians

As health care reform progresses (by fits and starts) I am impressed by the changing perceptions of specialist physicians which seems to be occurring regardless of anything that group did or did not do. For the past century or so specialists have been the most revered of practitioners because of their ability to coolly unravel a knotty clinical problem and bring to bear the latest technology to resolve it. As a result specialists have enjoyed well deserved prestige and income. Gradually over the past several years a different outlook has been emerging. This outlook is driven by the need to control the health care costs in this country and operates on the assumption that medical costs are driven by doctors (never consumers), that doctors provide services to prioritize income over medical necessity and that specialty care, being more expensive, is a prime offender. Some proposed solutions would structure our system so as to isolate the specialist and reduce him (her) to a technocrat.

Francis D. Horrigan, M.D., President

I do not accept the negative assumptions mentioned above. I would argue against them as demeaning to our profession while abhorring that miniscule fraction who might practice that way. Rather than that I would share some thoughts as to the role of specialists in our system and strive to include, not exclude, them in seeking solutions to real problems.

Specialists function in several roles i.e. research, teaching, consulting and doing. These levels of activity are crucial to the huge successes that American, (or any other) medicine has been able to achieve because they recognize that medical knowledge expands rapidly at a snail's pace as anyone who has done bench or clinical research can attest. The skills to do this kind of work include focusing on a specific area from the background of broad general knowledge. As a result people doing this work become quite specialized. As specialists develop knowledge there comes a point when it must be transmitted to other specialists, specialties or students and the specialist becomes a teacher by publication, presentation or lecture. Consultation extends teaching to the individual situation as does delivering the actual care. Either activity expands the experience and capability of the primary care physician producing a state of mutual professional growth to the benefit of the patient.

In performing these essential functions specialists can consume sizeable amounts of dollars to benefit subsets of the population. Costs of specialty care are substantial in terms of the investment required to attain the knowledge and skill levels, the costs of the equipment involved and the site of delivery as well as other costs not the least of which are

malpractice premiums which can be astronomic for some specialties. Critics are also wont to point out groups of people who may not benefit from technology or regional differences in its application. They usually fail to recognize that applications of technology need to be refined by practical experience—there is no other model. Regional difference studies, despite their best efforts, cannot be sure they are measuring exactly comparable practice settings. Outcome studies that show "lesser is better" often use harsh endpoints (like death) but fail to recognize quality of life issues such as a good level of function without spending hundreds to thousands of dollars annually in prescriptions and drug monitoring

Noting that, there continues to be a dilemma of appropriate conservative utilization and the application of new technology. We should not allow the resolution of this dilemma to be an adversarial structure pitting patients and physicians and one group of professionals against another. We should not allow this structure to be so labrynthine as to consume increasing amounts of administrative dollars that will benefit not one patient. It is not reasonable to expect that administrators, nurses or even primary care physicians will always be sufficiently knowledgeable to appreciate the proper application of specialty care in all instances.

As we recognize that resources for health care are limited and that the solo practitioner has a limited long term prognosis we should do those things to decrease divisiveness and promote teamwork such as

1) permitting physicians to organize and help define the appropriate use of resources

2) avoiding burgeoning and burdensome administrative requirements

3) developing a system to compensate injured patients without promoting huge legal costs and developing realistic patient expectations

4) funding research adequately so that our skill, knowledge and, yes, technology can continue to expand.

5) analyzing the supply side of health care—does something have to cost more because it has a medical use?

All parties working together in activities like these will be more productive than each party wasting energy protecting itself from the other. ■

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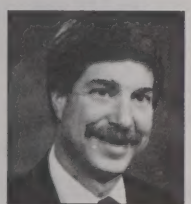

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President Clinton Talks Health Care with Physicians

In a satellite teleconference, the president says he supports antitrust relief, community rating, and physician empowerment

On March 23, President Bill Clinton addressed more than 600 California Medical Association members and guests following the association's annual meeting in Anaheim. The president appeared on screen via a satellite teleconference setup that enabled him to also see, hear, and converse with the CMA audience. After a brief speech summarizing his administration's health system reform plan, he answered several physicians' questions. The Hippocrat presents a condensed transcript of the question-and-answer session with the President.

Q President of CMA David Holley, M.D.: In your State of the Union address, you said that you would sign a health reform bill if it met the test of universal coverage. In addition to universal coverage, what other elements do you think critical to a reform package, and what must be included to secure your signature?

A President Clinton: To have a system that works, you not only have to have universal coverage, but the benefits ought to include primary and preventive care. There ought to be a comprehensive set of benefits. Then there ought to be a clear outlawing of insurance practices that have caused so much misery and caused so many Americans to fall between the cracks.

There should be an end to preexisting conditions and an end to discriminatory rate setting based on age. In order to do this, we have to find some way of not only legislating community rating, but actually having community rating.

We need a device that guarantees that small businesses and self-employed people will have access to insurance at rates competitive with people who are insured through big business and government.

If you are going to cover everyone, you have to either work through a tax or through some device by which people pay into an insurance pool. The employer mandate is the best way to do it by providing guaranteed private insurance at the workplace, because that's the way most Americans get their insurance today. I know there are some small businesses for whom this would create difficulty, so we've developed a system of small business discounts paid for from tax proceeds. The taxpayers would pay to cover those who are unemployed and uninsured.

Now, that is basically the way I think the system would have to work. There are lots of other things I think ought to be in it, but it is very important for the President... not to be too specific in talking about vetoes. If we can begin with a good comprehensive system of universal coverage, we can go a long way toward dealing with a lot of the other problems.

Q Kenneth Lane, M.D., San Bernardino family physician: ...In the current marketplace and under your proposed model, insurers and businesses are encouraged to collectively purchase health care services. ...What would you propose to provide a more balanced and fair environment

in which these negotiations can occur between physicians and insurers?

A President Clinton: We have to change the antitrust laws to allow you to organize...

While I like the fact that people are getting together in competitive buying groups and trying to get a better deal and trying to squeeze some of the excess costs out of our system—and we ought to agree that there are some there—I don't like the fact that an inevitable consequence of that has been that so many Americans have lost the right to choose their own doctor.

Under our plan, each American consumer once a year would have the right to choose from at least three plans. (These are) a fee-for-service plan, an HMO, and, hopefully, some sort of plan that... might allow all doctors in a state, for example, to participate, if they agree to observe the fee schedule that the plan bargains for. The HMOs should have to have a fee-for-service option that would allow people covered under the HMO to choose another doctor if it seemed appropriate. If the fee-for-service option were electively being given every year, HMOs would have to contribute to that.

I think that this will help. But I agree that there must be some changes in the antitrust law so you can clearly get together without fear of legal repercussions. Otherwise, you are consigned to dealing with a middleman who will only add to the cost of your providing your services and (will) undermine consumer choice.

Q Jane Marmor, M.D., Redwood City, Oncologist: ...We are concerned that your proposal and others might limit the rise of the health care budget to the cost of living or other artificial indices that might have little to do with the actual health care costs. Rising health care costs may be more related to human factors, such as our aging population, tobacco consumption, new technologies, or new diseases such as AIDS. How can these factors be taken into account when developing a health care budget?

A President Clinton: ...What we believe is that in the beginning, at least, there are many savings that can accrue from a rational system, (including) far lower administrative and

Continued page 9

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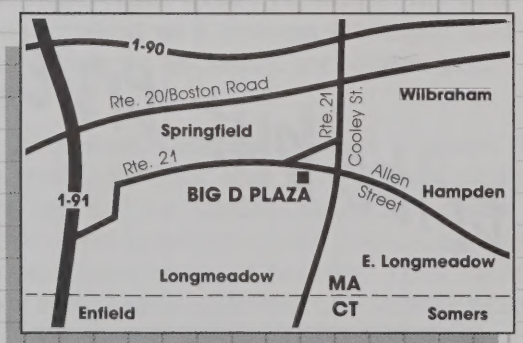

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In Memoriam

Jeffrey Lee Crosby, M.D., 40, passed away in November, 1993. Formerly of New York City and Glen Rock, NJ, a 2½-year resident at Baystate Medical Center, died at home.

Born in Margaretville, NY, he lived in Glen Rock before moving to New York City, and had lived here the past 2½ years.

He attended Allegheny College in Meadville, PA, and graduated with a bachelor of arts from Keene State College in Keene, NH. He also studied drama for three years at the Juilliard School, and took pre-med courses for two years at Hunter College, both in New York City. He graduated from New York Medical College. He was a member of Phi Beta Kappa and Alpha Epsilon Delta.

He leaves his wife, the former Patricia A. Schwoerer; a son, Nicholas A. at home; his parents, Leland H. and Margaret (Ashley) Crosby of Glen Rock, and two brothers, Michael of Houston, Texas, and Andrew R. of Hawthorne, NJ. ■

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For further information, contact Mr. Jim Curran, 43 Court Street, Westfield, MA 01085, (413) 568-8435 before July 30, 1994.

Health Care Reform

Continued from page 7

and bureaucratic paperwork costs. ...In the years ahead, when we measure how much cost can increase, we not only have to consider population growth and inflation, we will also have to consider the burdens of the American system.

If the rate of AIDS, for example, continues to go up instead of going down, if the rate of violence (increases), if the aging population imposes greater burdens rather than fewer because we don't succeed in doing a lot of the preventive things that we want to do—those things will all have to be calculated into the rate at which medical costs go up. We can't ignore real world factors that make the consumer price index in health care different from the overall rate of inflation. Those things should be taken into account.

Q Rene Bravo, M.D., San Luis Obispo Pediatrician: My question to you relates to the power of insurance companies. You have repeatedly stated that one of your goals is to return the control of medical practice back to physicians and hospitals. Unfortunately, many of the current managed care plans in California are moving away from that goal. Does your plan contain features that would achieve that goal?

A President Clinton: It does. There are some (provisions) that would help indirectly, and one or two that would help directly...

Saying that every consumer has at least three choices and that one of those choices must always be fee-for-service will put all these plans in competition with one another, and that will make a difference.

Secondly, making it easier for physicians to provide these services directly will dramatically minimize insurance companies' ability to add to the costs and delay and undermine the quality of health care by second-guessing everything doctors want to do in the HMOs that they are promoting. Those things will matter.

Third, our plan requires that insurance companies disclose what's in their utilization review protocol in advance so that people can evaluate that and know what's going on and argue against it. Competing plans, including competing physicians' groups, can say why this is a bad deal for you, why you shouldn't take it, and why this is going to add to the cost and undermine the quality of health care.

Most doctors I know recognize that from time to time there are certain things that ought to be subject to some kind of review, but basically it's gone crazy now. It has become an instrument for denying service when it's needed.

Q Dr. Holley: Mr. President, I think that the medical profession really believes that issue is so important that if we win everything else, but lose on that one, none of the others matter.

A President Clinton: It is absolutely clear to me that the whole HMO movement has taken the utilization review to an extreme and that it has to be backed off of. Forget about the HMOs. The insurance companies are driving this.

The more we can put doctors into the management decisions of HMOs, and the more choice we can give to the people—keep in mind, this is a huge deal letting the employees themselves make this choice instead of their employers—means that every plan will be chosen by someone who has had a personal relationship with a physician who has doubtless discussed this with him or her. That's going to make a big difference in this. I agree with you it is a very important issue.

Q Dev Gnanadev, M.D., San Bernardino Trauma Surgeon: ...We are really pleased that you believe tort reform should be an essential part of health system reform. Would you be willing to add to your plan the most essential part of (California's) Medical Injury Compensation Reform Act—that is, a $250,000 cap on noneconomic damages?

A President Clinton: ...We thought we ought to do something national, even though tort law historically has been completely within the purview of state government, not the national government. So we agreed that there ought to be a limitation on lawyers' contingency fees. We did some other things you recommended and that were in (California's) model work.

Something else we did, that has been insufficiently noticed, is we agreed to include medical practice guidelines developed by professional groups as raising the presumption that there was no negligence on the part of doctors. This offers an enormous opportunity to dramatically reduce the number of medical malpractice suits, the number of recoveries, and, therefore the malpractice rates.

Continued on next page

Health Care Reform

Continued from previous page

My own judgement is that we will not include the national cap, because there will be so much difference among the various congressional delegations from different states about what the cap should be and whether it should change with inflation over time. In fact, you might wind up in California with a situation different from the one you have now if (a cap were set)...

I urge you to look at what we have done, because I think we have taken a long step toward trying to relieve doctors of frivolous lawsuits and to control the cost of malpractice insurance.

Q Mattice Harris, M.D., Modesto Family Physician: ...I find that an enormous part of my day is spent battling with health insurance clerks to get authorization for my patients to get some of the most basic of health care. Obviously, it would be better for me to spend that time seeing patients. What will your plan do to prevent or limit the use of these managed health care organizations from throwing up these artificial barriers in the name of managed care, (when) in reality these things prevent us from providing that care?

A President Clinton: The micro-management of medicine by insurance companies has reached an excessive point. (Also) you don't want the federal government passing laws saying what decisions can or cannot be made by physicians.

What we tried to do is to change the whole system... We make it easier for people like you to join with like-minded physicians in providing services directly, or to join together and tell people that if you are going to work with them, you don't want those kind of utilization reviews. We require insurance companies to disclose their utilization review protocols in advance...

I also want to point out that if there is a single card, (as) we envision, that entitles a person to health care and enables them to hook into a computer that says they are covered, ...and if there is a single form related to the comprehensive benefit package that can be filled out in every doctor's office and hospital in the county and then be processed by every insurance company in the country, then that is going to dramatically reduce the paperwork burden...

It seems to me if you change the economics and change the distribution of the power of decision making, giving more to the doctors and the patients through the workplace—and less to the insurance companies—that (insurers') practices will inevitably change because of the shift in decision making.

Q Robert Hertzka, M.D., San Diego Anesthesiologist: ...There are some reform proposals that would cause purchasing pools or alliances to become so large and, thus, so inflexible that they would in fact limit, rather than enhance, the competition that...we want to see in the marketplace. What would you propose to control the size of the purchasing alliances so that they would fulfill their primary purpose of providing affordable, accessible care and not become large, inflexible bureaucracies?

A President Clinton: I agree that we should not allow them to become large and inflexible bureaucracies. Under our plan the alliances would be much larger and the membership would be mandatory. But that's because we are trying to achieve something with our plan that is beyond what the alliances do. Now this will all be debated in Congress, and I am certainly flexible on it. But let me explain why we recommended larger alliances.

The purchasing cooperative (HIPC) that you have in California, which has worked really well, is designed primarily to give small businesses bargaining power, so that they can in effect have the same access to health care at the same cost that people in large units like big corporations and government have.

What we wanted to do with the alliances were three other things that still have to be done somehow under the plan. First of all, through the alliances we were going to distribute the small business discounts, but we can find another way to do that. Secondly, we were going to provide certain handling services, basically to bring together and reduce the paperwork burdens of physicians, employers, and insurance companies... That can probably be done (under a different plan).

The other thing, which I think is very important, (is that) the alliances as large units were going to be used to make it financially possible for insurance companies to observe community rating.

There are two issues here on discriminatory rates. One is, how do you give small businesses

and self-employed people access to the same rate structure presently available to big business and government? The other is, how do you as a practical matter eliminate unfair billing practices without bankrupting the insurance companies that are still in the market—that is, how do you eliminate preexisting conditions? How can you afford to do away with lifetime limits? How can you eliminate rate discriminations against people with preexisting conditions in their families or against workers who are older at a time when older workers are having to change jobs a lot in their life, too?

Now, you can pass a law and say "we'll have community rating." But New York did that, and they still don't have it. The reason is they don't have any mechanism within which community rating can be practically made to work in a state where you have a lot of different insurance companies. The insurance companies simply cannot stay solvent and do that unless people are insured in very large pools where insurance companies can make money the way grocery stores do—a little bit of money on a lot of people... I am just trying to achieve an objective that we all agree is necessary.

Q Brian Johnston, M.D., Los Angeles Emergency Physician: ...Your proposal provides health security for all citizens and a $1 billion to cover noncitizens. ...We are spending close to $1 billion in Los Angeles County alone to deliver health care to undocumented immigrants. How do you feel we can better address this problem?

A President Clinton: Obviously, no state or local government should be required to shoulder the cost of immigration, or the lack of an immigration policy, or the inability to enforce the policy we have now at the national level...

Our plan will save the states enormous amounts of money that they would have paid otherwise in out-of-pocket Medicaid matched costs, long-term care costs, and such other health related costs as running public health facilities.

...If our plan goes into effect in 1996—or we begin to put it into effect in 1996, phasing it in—we estimate California will save about $6 billion or more between that year the end of the decade. New money that would not have been there otherwise in this budget will also allow the state to divert some of those resources to health care, as well as to deal with some of

Continued on next page

Health Care Reform

Continued from previous page

your long-deferred education and other problems. I believe that between the savings from the state of California and the funds that we can put into immigrant and migrant health care directly, we will make a big difference.

This fund will start at $1 billion, but obviously based on the evidence and on our ability to secure savings in other aspects of the system, Congress will be free to supplement the fund every year from now on. That's where we are going to start. I realize it doesn't solve the whole problem...

Q Aliza Lifshitz, M.D., Los Angeles Internist: ...In California our managed care system has evolved... into one that today is dominated by large-for-profit, publicly traded HMOs. This evolution has caused those HMOs' profits and administrative costs to soar... CMA is sponsoring legislation in California to limit the administrative costs and profits of these companies. How do you feel about this situation, and how would your plan protect other states from this trend?

A President Clinton: In two or three ways. First of all, under our plan (HMOs) will have to offer pap smears, mammograms, and other preventive and primary services. They won't be able to cut them out. Secondly, these companies will be under much more pressure to provide quality service and to siphon less money off to bureaucracy and profits then they are now, because they won't be able to make a deal with employers, which then can be forced on employees.

Every employee, that is every patient you see, will be able to make a new choice of plan every year. So, if they get abused in year one, then in year two they will be able to make the same choice they made last year and choose a different plan, fee-for-service medicine, or a group of physicians who are providing health care. So this will fundamentally change the whole incentive of the system...

Then we will change the antitrust laws to make it even easier for physicians to get together and deliver health care directly. So, these HMOs are going to be under a whole different kind of competition. It won't be competition from someone else providing less service at lower costs. It will be competition from someone else providing more services and higher quality with more choices for the same costs, or sometimes less. I think this will really change things and put you and your patients much more in the driver's seat than you are now. That is perhaps the most critical element of my plan that has not been really noted...

Dr. Holley: *Mr. President, everyone in this room and all the people we represent would like to thank you for taking the time from your busy schedule to meet with us today. We want you to know that we are with you in this fight, and we join with you in working with Congress in a joint effort to guarantee all Americans private health insurance that can never be taken away.*

President Clinton: Let me just say in closing: If I could ask you one thing it would be to impress upon the Congress the importance of acting, and acting this year...

You know more uniquely than most people do what the consequences of not doing anything are. And that's more restrictive managed care, more people without any insurance at all, more of the headaches that you have already complained about today. Work with me on the details and impress upon your very large congressional delegation that the time to act is now. Not next year, not five years from now, but *now.* Thank you. ■

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Hampden Committee Activities

The Public Health Committee met in March and April. Deloris Williams, Springfield's Public Health Commissioner, reported that the Southwest Community Health Center is in the process of answering a request for proposal that would provide additional funding to that already received. The Society may be asked to write letters of support. The commissioner also asked for our help in setting up a media campaign concerning the ordinance banning smoking in public places. The ordinance was recently passed by the Springfield Public Health Council. It is hoped that a media campaign would help to get the ordinance made into a law. Dr. Sheffield reported that he has obtained slides from Boston University for his STD presentation. He is at present trying to get the program going in the East Longmeadow and Westfield schools.

The Medico—Religious Committee met in March to firm up plans for the 10th Annual Medical Ethics Seminar to be held on October 19, 1994. Professor Arthur Dyck of the Harvard Divinity School, who spoke at our 1st seminar ten years ago, has accepted our invitation to speak at our 10th. Because the committee asked Professor Dyck to speak, they felt it was only fair to ask the panelists from ten years ago to once again participate. Rev. Benander and Dr. Robert Kasper accepted. Attorney Theodore Brown, Rabbi Jerome Gurland, and Rev.John Tuohey will be asked. The Committee members discussed the fact that a large portion of our attendance is the nurses. They decided an R.N. should be added to the panel. They asked Beth Drummond and she accepted.

The Medico—Legal Committee met in April. Attorney Phelps asked for our help at the last meeting concerning physician volunteers to serve on medical tribunals in Berkshire County. Dr. Mullan asked for volunteers at our January District Meeting and a notice was placed in the Hampden Hippocrat. To date, 8 physicians have volunteered. Dr. Mullan informed the committee members that the "Interprofessional Guidelines" were approved at our January District Meeting. The committee members discussed plans for the Forum to be held on November 3, 1994. Needed for the Mock Medical Tribunal are, a judge, a doctor, and three lawyers. 1 to serve on the panel, 1 to be a plaintiff lawyer, and 1 to be a defense lawyer. The Medical Society was asked to obtain the physician, and the Bar Association will obtain the judge and lawyers. They will also work up a case. Attorney Bagley reported on the problem with subpoenas that Dr. Chircop brought to the attention of the committee at the last meeting. He attended a meeting of the MBA and brought forth the idea of changing the law on subpoening physician's office records. It was favorably received by the Civil Litigation section of the MBA. A year ago the hospital record statute was amended allowing hospitals to give up hospital records with a subpoena, as long as the patient whose records were being sought, was a party to the case. There is no such rule pertaining to physician records and there should be. Attorney Bagley will continue to move this through the Civil Litigation Committee.

A Legislative Breakfast was held on April 8, 1994 at the Springfield Marriott. 49 physicians and legislators attended. Representatives Barsom, Caron, Chesky, Knapik, Murphy, Rogeness, Scibelli, and Walsh attended, as well as aides from the offices of Senator Lees, Senator Melconian, Senator O'Brien, and Representative Petrolati. The legislative issues discussed were House 4161 "An Act providing Non—Discriminatory Standards for Physician Contracts", House 1271 "An Act Relative to Shared Liability for Injuries Associated with Utilization Review Activities", and House 4165 "An Act Relative to Public Disclosure by Health Insurers".

The Executive Committee met in February, March and April. Ms Barnes, our Public Relations

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Medical Education In Japan

Dr. Maura Jo Brennan, a fellow in geriatric medicine at Baystate Medical Center, has prepared an analysis of medical education in Japan for us on her return from her Fulbright year there.

Last year I spent a year in Japan on a Fulbright research grant studying Japanese medical education as part of my fellowship in general medicine/geriatrics at Baystate Medical Center. It was a fascinating experience which exposed me to a very different approach to medical training.

The current Japanese system is a unique patchwork quilt of traditional Asian values, and the German and American models. This reflects the history of medicine and medical education in Japan. Prior to the late 19th century, with minor exceptions, medical training was in the Chinese school of medicine and based on an apprenticeship system. In the 1870s Japan adopted a scientific, Western approach to medical training as part of its national program of modernization. Tokyo imported a number of Western scientists and clinicians (most of whom were German) to oversee the revamping of their medical education system. Their influence lingers on today in the six-year medical schools, the stress on research and scientific inquiry, and the compartmentalization of Japanese hospitals and medical schools. After Tokyo's defeat in World War Two, the American occupation of Japan resulted in some restructuring of medical education, particularly at the graduate level and a version of the rotating American internship was instituted (although this was subsequently revised).

Tokyo imported a number of Western scientists and clinicians to oversee the revamping of their medical education system.

For the Japanese youngster, education is seen as the key to success in life. For some students, the "examination hell" of competition and school entrance tests may commence as early as nursery school. Virtually all students are under enormous pressure from middle school on to excel. Medicine is perceived to be one of the best careers open to only the brightest. Students apply to medical school while in high school and must pass both an exacting national entrance exam and a gauntlet of tests administered by individual schools to which they apply.

After admission, the Japanese medical student spends six years in a European—style combined undergraduate—medical school program. There are significant differences in curriculum among schools, but for the most part, the first two years are spent in courses that American students would do at the college level. The middle two years are the rough equivalent of the preclinical years of American medical school and the final two years give students some clinical exposure and time to review for a national licensing exam which all graduates must pass prior to beginning postgraduate training.

The experience of Japanese medical students contrasts with that of their American counterparts in a number of ways, but the most striking difference is the limited nature of their clinical exposure. This reflects a complicated mix of legal and cultural factors. There is no clerkship or subinternship system in Japan and students have minimal responsibility and are not perceived to be integral members of a patient care team. They usually spend over a year rotating through dozens of subspecialties at two to three week intervals largely as observers. This reflects an ingrained Japanese approach to training which stresses "learning by watching

the teacher from behind."

The postgraduate training system is difficult for an outsider to fathom. To begin with, there is extraordinary variation from hospital to hospital and program to program. There is no equivalent of the American Council for Graduate Medical Education or Residency Review Committees to ensure a certain level of standardization. Supervision by the Japanese Ministries of Education and Health and Welfare is rather loose.

The government recommends at least two years of postgraduate training and compliance is near total but the content of these programs is quite uneven. Training programs may be at either university centers (private, national or public) or non-university teaching hospitals.

About ⅔ of Japanese medical students remain at their undergraduate institutions for postgraduate training. The same number choose "straight" programs in which they enter subspecialty training immediately after graduating from medical school. Thus, it is possible, for example, with virtually no exposure to general internal medicine while in medical school to directly enroll in a cardiology program as an intern. 31% of trainees go into "rotating" programs where they shift among various departments. Only 3% of programs are classified as "comprehensive" and include exposure to emergency medicine and basic pediatrics.

A number of other factors in the early postgraduate years tend to limit clinical skills acquisition and training. These include less structured teaching time, fewer patients on service, fewer call nights, and longer average lengths of stay for patients than an American observer would expect. (The average length of stay in national teaching hospitals is 38 days.)

After the two years of government recommended postgraduate training is completed, most Japanese doctors continue on with subspecialty training. It is worth noting there are only a small minority of hospitals with departments that are primary care oriented. Few institutions have divisions of general internal medicine or family practice, for example.

In summary, the Japanese medical educational system is a distinctive blend of varying traditions which reflect its own cultural and historical roots. Its most notable strength is its emphasis on the science of medicine and its strong academic orientation. On the other hand, its most striking weakness lies in its overproduction of clinically narrow subspecialists and the dearth of physicians that it yields who are qualified to provide general primary care to the Japanese people. ■

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Optimal Care of the Diabetic Foot

This update on a problem of concern to physicians from multiple disciplines is offered by Dr. Jeffrey Kaufman, a Vascular Surgeon at Baystate Medical Center.

Residents of Western Massachusetts suffer an alarmingly high incidences of diabetes mellitus. Baystate Medical Center, for example, has diabetes as a comorbidity in approximately 12 percent of hospitalized patients, and this is one of the highest rates in New England. Physicians in this region therefore have a special responsibility to treat all of the complications of diabetes.

Diabetic foot disease is receiving increasing public attention as a cause of amputation. The lifetime risk of any amputation—toe, midfoot, or leg—for anyone with diabetes has been estimated at 1 in 6, which translates to the startling reality that approximately 2 percent of patients hospitalized at Baystate will, in their lifetimes, suffer tissue loss directly attributable to diabetes. Clearly, the best program for management of the diabetic foot is prevention of disease.

The last decade has been notable for significant improvement in the surgical treatment of diabetic vascular disease as it affects the foot. Although the microvascular capillary membrane thickening of diabetes has received attention for nearly 20 years, it has been established as part of the pathophysiology of diabetes only in the eye and kidney. In the foot, the dominant problems are neuropathy (which is probably related more to abnormal sugar metabolism involving inositol/myoinositol metabolism) and *macrovascular* vascular disease in the "named" arteries of the body. A decade ago, significant ischemia complicating wound healing was appreciated in only 20 percent of patients, and the limb loss rate for serious infections or gangrene in the diabetic foot approached 40 percent. In the 1990s, with present techniques of wound management, using unusual partial foot amputations and aggressive revascularization beyond the majority of extant disease, the limb salvage rate can exceed 90 percent. Currently, one of the commonest types of vascular reconstruction in the diabetic population is a bypass extending to a distal tibial artery or onto the foot to a pedal vessel which may be as small as one millimeter in luminal diameter. At Baystate, the rate of major amputation—below-knee and above-knee—has been clearly reduced in the last five years, whereas the rate of partial foot amputation has increased.

Initial management of a serious infection involves broad spectrum antibiotic coverage: If the infection appears limited to the toes or forefoot, one may use imipenem as a primary agent, but if there is any spread to the midfoot, or if there is a major systemic reaction to sepsis, broad spectrum coverage with multiple agents is preferred, often with aztreonam and clindamycin. In recent years, alternative agents have allowed us to avoid aminoglycosides and their associated toxicity. Diabetic infections are usually necrotizing, with a phlegmon which destroys tissue through thrombosis of visible small arteries and veins. There is frequently an associated sequestered infection in a joint or a site of osteomyelitis which provokes the spread of sepsis. The initial debridement must remove this dead or compromised tissue. Although an initial survey radiograph of the foot is helpful to locate chronic osteomyelitis, nuclear and magnetic resonance scans to define infection have been no where near as effective in localizing infection as is a careful physical examination by a physician experienced in diabetic foot infection. A patient with ischemia and a serious

infection will receive an early excisional drainage of the necrotic tissue, angiography, reconstruction, and a secondary procedure for wound closure within the first week of hospitalization. These results reduce the morbidity, shorten hospital stays, lessen the difficulty of rehabilitation, and decrease the overall costs to society of these serious infections.

No one fully understands why the diabetic foot develops ulcers. Clearly, it is a multifactorial problem, commencing with neuropathy. Without a functioning pain-withdrawal reflex, ulceration can occur anywhere in the body. In the foot, comorbid factors in ulceration include: (1) Loss of intrinsic muscle function and inequality of calf anterior-posterior muscle group strength, which brings the toes into hammer deformity (dorsal subluxation). Hammer toes are predisposed to dorsal injury, with ulceration into the interphalangeal joints. There is increased exposure therefore to plantar pressure on the metatarsal-phalangeal joints, which leads to the classic "malperforans" ulcer. (2) Loss of transverse metatarsal arch and longitudinal arch structure of the foot. At an extreme, the collapse of the arch structure leads to the Charcot "rocker bottom" foot, with a huge non-healing plantar pressure sore aligned with the shaft of the tibia. In the less extreme cases, the rounded "ball" of the foot has prominence of the second, third and fourth metatarsal heads, which readily ulcerate. The peculiar osteoporotic character of foot bones in advanced diabetes has not been explained, but the loss of structural integrity of the midfoot is a disastrous consequence for patients with advanced diabetes. (3) Loss of skin and subcutaneous fat integrity. For reasons not yet understood, there is typical thinning of the plantar fat pad of the foot and loss of resistance of the foot to shear forces. Ulceration is not simply a matter of static pressure applied to the foot. As we walk, a wave of pressure moves from the heel site of touchdown along the lateral metatarsal rays of the foot, then transversely over the metatarsal heads, culminating in pressure on the toes, mainly the first, as the foot pushes off. all of the motion of this pressure wave involves shear, a force vector parallel to the skin. It is this stress which results in blistering, which in turn leads to infection. Another site prone to shear and compression stresses is the heel. With compression and relaxation during normal gait, the dry and callused heel skin will fissure, especially during winter when the skin is unusually dry. These wounds can prove remarkably refractory to healing, because the heel pad is a site with less perfusion then other parts of the foot in all patients, whether diabetic or nondiabetic.

The root causes of these problems is therefore beyond treatment in 1994. It is generally believed that the best overall approach is through "tight" control of blood glucose levels. Recent trials have confirmed the efficacy of multiple injections of insulin to give the most optimal lowering of glucose levels. Prevention of foot disease involves prophylactic measures to protect the skin envelope and surgery to treat deformity. The first measure are the provision of proper foot wear and podiatric care. These are backed by an education program to avoid behaviors that injure diabetic feet. Patients need to have their feet inspected daily, avoid walking stresses on the feet, use proper footwear at all times, have professional nail and callus care, and have an extremely

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Optimal Care

Continued from previous page

low threshold to obtain care from a surgeon, podiatrist, physician or nurse interested in the diabetic foot for questions about tissue integrity. The general surgical and orthopedic management includes elective osteotomies or metatarsal head resections to move the points of maximum stress away from the forefoot, correction of hammer toe deformity, and management of midfoot bony collapse.

Healing the diabetic foot requires the services of a wide variety of medical professionals, including the input of infectious disease specialists, radiologists, dietitians, nurse educators, and visiting nurse associations. Our community is also blessed with podiatrists and pedorthotists who are able to prepare excellent diabetic footwear. These shoes provide extra depth for the toes, are fully lined with soft leather, and include molded plastic inserts to spread static pressure load over the whole plantar aspect of the foot. The importance of footwear has been recognized in 1993 by HCFA, which now includes special shoes as a Medicare benefit for patients with defined neuropathy, a past infection, or an amputation.

Attitude and education are most important in preventing a diabetic ulceration and infection can be prevented. Responsibility and communication are essential. The patient's family must be involved in a daily program of foot care and inspection to search for breaks in the skin. Any lesion must be brought to the immediate attention of a practitioner interested in care of the diabetic foot. The patient alone cannot manage this program of inspection and care, because most people with advanced diabetes have enough difficulty with vision and joint mobility in the legs and feet to prevent an adequate evaluation of the foot. The enemy is denial, which is promoted by neuropathy. Families must be reminded that the typical patient will deny a serious foot problem because it is not causing pain, although a red, draining, fetid wound may be obvious. Because so many of these infections prove to be an emergency, our office routinely arranges for any patient with a question of a diabetic foot infection to be seen within 24 hours in the office. Baystate Medical Center now has a consultation service for these specialized foot problems.

Most patients who will come for consultation will already have a family physician, internist, endocrinologist, or podiatrist. The Consultation Service will work with them to optimize the condition of the foot. Diabetic foot disease is chronic and is best managed on a daily basis by the medical team close to the patient's home. Patients should not need to travel long distances outside the Pioneer Valley for the special care required by the diabetic foot. ■

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Michael G. D'Alessandro, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 25, 1958
Premed: University of Massachusetts 1977-1992
Medical: University of Massachusetts Medical School 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Internal Medicine/Pediatrics
Resident

Allan L. Markus, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 10, 1964
Premed: Union College, Schnectady, NY 1982-1986
Medical: University of Medicine & Dentistry of NJ
New Jersey Medical School, Newark, NJ 1986-1990
Internship: University of Rochester 1990-1991 (Internal Medicine)
Residency: University of Rochester 1991-1992 (Neurology)
Baystate Medical Center 1992-Present
Specialty: Internal Medicine
Resident

Victoria P. Peters, D.O.
540 Meadow Street, Ext.
Agawam, MA 01001

Born: March 18, 1961
Premed: Hofstra University New York 1979-1983
Medical: New York College of Osteopathic Medicine 1983-1987
Internship: Long Beach Memorial Hospital 1987-1988
Residency: Long Beach Memorial Hospital 1988-1989
Fellowship: University of Medicine & Dentistry of NJ 1989-1991
Specialty: Family Medicine/Geriatrics

Dennis A. Cortes, M.D.
P.O. Box 10413
Holyoke, MA 01041-2013

Born: August 20, 1962
Premed: University of Puerto Rico 1984-1988
Medical: Universidad Central del Caribe, School of Medicine, Puerto Rico 1985-1988
Internship: Veteran's Administration Hospital, Puerto Rico 1989-1990
Residency: Veteran's Administration Hospital, Puerto Rico 1990-1992
Specialty: Internal Medicine

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Continued from previous page

Kevin R. Bock, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 7, 1966
Premed: University of Rochester 1984-1988
Medical: Loyola University Chicago, IL 1989-1993
Internship: Baystate Medical Center 1993-1994
Residency: Baystate Medical Center 1994-Present
Specialty: Internal Medicine/Pediatrics Resident

Scott M. Cochrane, M.D.
1767 Northampton Street
Holyoke, MA 01040

Born: November 18, 1952
Premed: University of California, Davis 1970-1974
Stanford University, CA 1974-1976
Medical: University of North Carolina 1986-1990
Internship: University of Massachusetts Medical Center 1990-1991
Residency: University of Massachusetts Medical Center 1991-1993
Specialty: Pediatrics

Winthrop F. Whitcomb, M.D.
Meadows Medical Associates
200 North Main Street
East Longmeadow, MA 01028

Born: November 6, 1962
Premed: Wesleyan University, CT 1982-1984
Connecticut College 1980-1982
Medical: Jefferson Medical College 1985-1989
Internship: Baystate Medical Center 1989-1990
Residency: Baystate Medical Center 1990-1992
Specialty: Internal Medicine

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Hampden Committee Activities

Continued from page 13

Consultant, reported that $22,500.00 has been awarded for the "Draw Against Joe Camel" program. This program will work in conjunction with our Annual Poster Contest.

The MMS held a Media Training Session on March 1, 1994 at the Regional office in Northampton. Drs. Horrigan, Papale and Ross attended. The course consisted of a surprise on—camera interview. The course was useful in generating certain techniques emphasizing physical appearance and body language. It is hoped the program will be repeated for each generation of leadership coming along.

Ms Barnes also reported that the House Calls Program held on April 10 was a success. The topic was Heart Disease and the new Cholesterol Guidelines. Hampshire District Medical Society also participated in this program. Physician volunteers manned a phone bank and took calls from the public in Hampshire district. Noble Hospital conducted free cholesterol screenings on April 11th. ■

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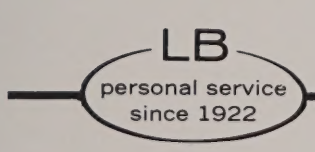

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